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March 5, 2021

President Joseph Biden
Vice President Kamala Harris
1600 Pennsylvania Ave
Washington, DC 20500

Summary Recommendations to Ensure Physician Capability to Provide Optimal Medical and Functional Health Care Access for American Patients During the Biden Administration

Dear President Biden and Vice President Harris,

On behalf of the American Academy of Physical Medicine & Rehabilitation (AAPM&R), I am pleased to share with you and your colleagues in the Biden-Harris Administration our recommendations to ensuring optimal medical and functional health care access is available for all Americans, including during the COVID-19 public health emergency (PHE), by protecting physicians' capability to provide such care. Thank you, in advance, for your attention to these issues. I would also like to thank you for your quick work in the early days of your administration to expand use of the Defense Production Act to produce much needed medical supplies, create the Pandemic Testing Board to increase testing capacity, and direct studies to identify COVID treatments and collect data that consider diverse populations. Please consider AAPM&R a resource in your work to fight the COVID-19 pandemic.

AAPM&R is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, are medical experts in treating a wide variety of conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

I. COVID-19 Priorities for Physiatrists and Rehabilitation Patients

Physiatry's Unique Position in Treating COVID-19 Patients and Post-COVID Syndrome Patients: Physiatrists, as trained physician experts in

rehabilitation, will continue playing a unique role in helping American patients recover from COVID-19. As you know, COVID-19 can be a devastating virus that affects pulmonary, cardiac, and neurological function. On top of recovering from the disease itself, necessary treatments for dire cases of COVID-19, such as intubation, can result in impaired swallowing, difficulty speaking, muscular weakness, and pain after weeks of being sedated. Physiatrists are uniquely able to devise rehabilitation programs aimed at restoring function and maintaining optimal health for these patients to return to their lives and work after they were upended by the novel coronavirus.

In addition to patients who suffered severe cases of COVID-19, more and more survivors of mild and moderate COVID-19 cases are suffering lingering symptoms and being diagnosed with post-COVID syndrome. Post-COVID syndrome outpatient clinics are beginning to open around the country, and resources and infrastructure are needed to continue to support these efforts to help these patients address their symptoms and to help our health care system better understand this new disease. Physiatrists are the leading physicians developing the care plans, coordinating the needed care, and conducting research to treat post-COVID syndrome.

As such, we urge your administration to consider the following recommendations to help physiatrists working in inpatient and outpatient facilities best care for COVID-19 patients, even after the declared public health emergency (PHE) ends.

A. Protecting Physiatrists

Personal Protective Equipment and Adequate Testing: Nearly a year after the declaration of the PHE, many hospitals and practices are still having difficulty acquiring Personal Protective Equipment (PPE). We implore you to continue your efforts to manufacture PPE but also to ensure that PPE is made widely available to all facilities, health care workers, and other health care staff in the United States throughout the PHE and afterwards, if shortages continue. All physicians and health care workers require PPE to work with patients to ensure personal, patient, and community safety from the spread of COVID-19.

In September 2020 CPT code 99072 was created to report additional PPE and clinical staff time associated with the PHE. AAPM&R urges the administration to mandate coverage of this code with no associated patient cost-sharing during the PHE. Further, we support that this coverage should

not be subject to budget neutrality. As noted above, PPE at this time is critical to patient and provider safety. It should not be an out-of-pocket cost to providers who are already struggling to keep their practices open.

In addition to expanding the supply of PPE, AAPM&R implores the new administration to increase access to accurate testing. Many patients who originally required procedures and services that were considered “non-essential” are starting to return to hospitals to catch up on these procedures and services, which may have not been exigent but are truly essential to maintaining health and quality of life. Many hospitals are testing such patients for COVID two days prior to any procedures they have planned as a safety check. Not all hospitals and many independent practices cannot afford this. We ask Congress to do what it can to provide testing to facilities.

Medical Liability: As physicians continue providing life-saving care in good faith with limited equipment, resources, and understanding of this new virus, we ask that greater medical liability protection be provided to physicians working across the country. We urge you to work with Congress to include the targeted liability protections in the bipartisan Coronavirus Provider Protection Act (recently HR 7059) in any upcoming COVID-19 legislative package. Due to the ongoing burden of suspected and confirmed cases of COVID-19, physiatrists, like many medical specialists, continue to heed calls to expand their day-to-day patient care responsibilities. This includes joining the frontline in providing critical care to highly contagious COVID-positive patients, providing post-COVID rehabilitation to patients with limited knowledge of the disorder, and volunteering to provide vaccines to protect and improve the public’s health.

We appreciate Congress’ effort to expand liability protections in the CARES Act to provide civil immunity to physicians and clinicians who volunteer to provide care during this public health emergency. However, additional protection is needed for physicians, including those who were and are not providing direct care to COVID-19 patients, but whose medical practice and treatment decisions have shifted due to the pandemic. Such protection should explicitly limit provider liability for harm resulting from government directives to cancel, delay, modify (e.g., treatment via telehealth) or deny care as a result of the PHE. Physiatrists, like other physicians and clinicians, continue to face tremendous burden as they work to restore the pulmonary function of COVID-19 patients, treat muscular weakness and deconditioning from the illness, and expand care to cover the overflow of patients entering inpatient rehabilitation facilities, where physiatrists traditionally practice. During the height of the pandemic and during resurgences, our members

across the country put themselves at risk by working in dramatic and unique situations, such as treating patients without proper PPE, admitting acute care overflow patients to inpatient rehabilitation facilities. These circumstances raise concerns regarding the threat of medical liability lawsuits for rehabilitation health care providers, due to circumstances that are beyond their control. As psychiatrists and other health care workers put their practices and lives at risk to treat COVID-19 patients with limited PPE, delay care to patients whose conditions are considered “non-essential,” and potentially take on an overflow of patients they may not normally treat, they should not be concerned by the potential threat of years of costly litigation resulting from these unforeseen circumstances.

Maintaining the Psychiatry Workforce: As stated earlier in this letter, psychiatry’s contribution to COVID-19 recovery is unique and integral to ensuring that the many current and future patients who contract the virus can return to their optimal level of function. It is no secret that the nation has been facing a physician shortage,¹ even before COVID-19, which is infecting physicians and clinicians working with COVID-19 patients. As such, it is imperative that the psychiatry workforce is enhanced during the COVID-19 crisis by recapturing unused immigrant visas. We urge you to work with Congress to include the Healthcare Workforce Resilience Act (recently S. 3599) and the Conrad State 30 and Physician Access Reauthorization Act (recently S. 948) in any upcoming COVID-19 legislative package.

AAPM&R has members who would directly benefit from the passage of these bills as they await extraordinarily long lines for their green cards. According to one member, who is an Indian citizen and psychiatrist working in West Virginia, the estimated wait time for his green card is over 40 years. This psychiatrist is providing care to American patients in a rural area, an already underserved community. Ensuring psychiatrists like him and others can continue to provide care will keep us from deepening the American physician shortage during the PHE and as the nation continues to recover from the pandemic.

¹ According to an Article in Human Resources for Health, it is estimated that in 2020 there is a shortage of 91,500 physicians. (Zhang, X; Lin, D; Pforsich, H; Lin, VW. *Physicians workforce in the United States of America: forecasting nationwide shortages*. Human Resources for Health. February 2020. Retrieved here: <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-020-0448-3>

Additionally, allowing American-trained immigrant physicians who have J-1 nonimmigrant visas to stay in the country after their training, rather than working for two years abroad after training before applying for their visa or green card, would immediately increase the number of physicians and physiatrists working in the country as it heals from the COVID-19 pandemic. These physicians are required to work in underserved and academic medical centers, serving not only patients but the broader public health interest by providing access to health care in areas that lack capacity.

B. Financial Security

Telemedicine: We appreciate all that Congress has done to ensure telemedicine flexibility while citizens are social distancing to reduce risk of infection. AAPM&R has found these measures vital to treating patients during this tumultuous time. We encourage Congress to ensure that telemedicine, whether audio-only or audio and visual, are accessible throughout the country and to all patients.

As patients are able to return to physician offices, telehealth is still heavily relied on and AAPM&R recognizes that adequate telehealth coverage will continue to be critical. To maintain appropriate social distancing and complete need sanitizing of rooms and equipment in reopened practices, telehealth will need to continue to be used for at least a portion of patients. This includes offering telehealth to the immunocompromised patients including those frequently seen by physiatry such as patients with spinal cord injuries and traumatic brain injuries, as well as patients in need of routine follow-up that does not require in-person care. Telehealth is being used to reduce the number of in-office patients while still ensuring that all patients are able to access the care they need. We urge your administration to maintain existing waivers for telehealth services until physician offices can return to pre-COVID practices in their waiting rooms and patient rooms.

AAPM&R is grateful for the critical telehealth flexibilities advanced in the PHE. One of the most immediately meaningful flexibilities has been the coverage of audio-only telehealth encounters at a rate comparable to in-person or real-time audiovisual telehealth evaluation and management services. It is our understanding that HHS intends for this flexibility to end with the PHE.

AAPM&R asserts this flexibility should be maintained permanently. Our members have reported using telephone-only visits in place of real-time

audiovisual telehealth for a variety of different types of patient encounters. For example, it has been a way to conduct comprehensive follow-up visits with their spinal cord injury patients they typically would have seen in the outpatient hospital setting. These patients can verbally report on their function, improved or worsening spasticity, and bowel issues even though a physical exam is not completed. A historical account of these conditions can result in a process of medical decision making similar if not identical to when a service is provided face-to-face.

A large portion of our members practice in the musculoskeletal and/or pain management space. Due to the non-urgent nature of many of the procedures these physicians perform, many of these practices are either closed to in-office visits or are seeing only the most urgent cases. For these members, the telephone has become their primary tool with patients who do not have access to or agility with real-time audiovisual technology. As with the spinal cord injury patients previously described, these patients can be assessed verbally with respect to their function in a way that approximates a physical exam such that our members can confidently consider changes to their plan of care including medication management.

We understand our members are using the telephone to remove barriers to care for their patients during this challenging time. Further, we recognize there are many other appropriate uses for audio-only telehealth services which will remain applicable at the conclusion of the PHE. Therefore, AAPM&R urges this administration's HHS to permanently allow audio-only telehealth visits and to appropriately reimburse physicians for this work.

Further, we ask that the administration work to prioritize changes to the Social Security Act which would allow for broader use of telehealth beyond the PHE. Under the PHE, Medicare has been able to waive geographic restrictions which limit Medicare telehealth coverage to patients in designated healthcare professional shortage areas who present at designated originating sites for telehealth. These policies extremely restrictive policies will go back into effect after the PHE unless action is taken. AAPM&R recognizes the significant benefits to allowing all beneficiaries access to telehealth on a permanent basis. Further, we believe one of the key benefits of telehealth is allowing beneficiaries to access care from their homes rather than having to travel to an originating site. We urge the administration to address these limitations in telehealth policy prior to the conclusion of the PHE.

Student Loans: As many of our members in the private practice and outpatient setting are closing their doors, being furloughed, and being laid off, we ask for student loan relief for physicians by passing legislation such as the Student Loan Forgiveness for Frontline Health Workers Act (recently HR 6720) in any upcoming COVID legislative package. This bill will directly help psychiatrists helping COVID-19 patients recover or those who are taking on overflow acute care patients in their post-acute care inpatient rehabilitation facilities.

As the pandemic has highlighted, physicians play a special part in society by keeping Americans healthy. During the COVID-19 outbreak, many “non-essential” procedures were halted to prevent the spread of the virus. However, “these non-essential” procedures can make all the difference in the quality of life and capabilities of Americans. These “non-essential” procedures are also the livelihoods of many psychiatrists who have incurred hundreds of thousands of dollars of debt to become physicians. As such, we ask that a broader student loan bill be introduced such that all physician borrowers can apply for their student loans to be given additional flexibility and relief.

C. Patient Access to Necessary Care

Access to Outpatient and Post-Acute Care for the Uninsured: We appreciate Congress’ 2020 efforts to set aside funds to pay for treatments related to COVID-19 for the uninsured through the Provider Relief Fund. While the effects of COVID-19 are still being discovered, we do know the effects can be devastating and that many Americans infected are being put onto ventilators. The American Hospital Association estimates that 960,000 people will need ventilators to prolong their life and fight the virus during the pandemic in the United States.² Patients who require prolonged ventilation, meaning ventilation that is not used following surgery or other routine care, often need post-acute care (PAC) to restore respiratory muscles to optimum function. Additionally, patients who require prolonged ventilation have not moved in weeks and may require rehabilitation to help with muscle weakness and pain. COVID-19 patients at all ages are showing persistent cardiac, pulmonary, and neurological effects. We are grateful for the Congressional funding to hospitals for free COVID testing for the uninsured. However, we believe all treatment, should also be waived for the

² Sullivan, Peter. Severe Ventilator Shortage Sparks Desperate Scramble. March 26, 2020. <https://thehill.com/policy/healthcare/489734-severe-ventilator-shortage-sparks-desperate-scramble>

uninsured. This includes any post-acute care and subsequent outpatient rehabilitation needs to restore respiratory and other muscle function and to treat post-COVID syndrome. Outpatient practices can be a vital extension of inpatient care, as they ensure patients who have been discharged maintain their functional gains from the inpatient setting. Such follow up may need to be virtual, so there should be continued incentivization of virtual visit options.

Social Determinants of Health: AAPM&R is concerned about the disparate impact of COVID-19 on minority communities. While health disparities in minority populations is not new, COVID-19 has certainly exacerbated and highlighted the ongoing problem of social determinants of health (SDOH) in our nation. AAPM&R has been consistently advocating for a bill collecting data on minority communities, including but not limited to people with disabilities, be included in the upcoming COVID legislative package. The Equitable Data Collection and Disclosure on COVID-19 Act, introduced by Reps. Ayanna Pressley, Robin Keely, and other members of the Congressional Black Caucus, along with Sen. Elizabeth Warren, requires the Department of Health and Human Services (HHS) to collect and report racial, ethnic, and other demographic data on COVID testing, treatment, and fatality rates. AAPM&R strongly supports this bill and its inclusion in the upcoming COVID legislative package. However, we also require edits that (1) integrate the concerns and interests of the disability community throughout the bill to ensure that disability rights are universally considered civil rights, (2) include on the mandated data collection commission agencies with disability, independent living, and rehabilitation research portfolios, and (3) authorize targeted COVID research funding to NIDILRR comparable to the targeted funding provided to other research agencies.

In addition to collecting this data on SDOH during the COVID-19 pandemic, we ask that this administration work to include language stating that medical researchers who have similar backgrounds to the minority groups be provided equitable funding. For example, any projects researching the disparate effects of COVID-19 on the Black and African American communities should include funding for a Black and/or African American researcher. Studies have found that lower rates of NIH R01 awards go to African American and Black scientists than White scientists.³ This study controlled for education background, country of origin, training, previous research awards, and employer characteristics. Black and African American

³ Hoppe et al., Sci. Adv. 2019;5 : eaaw7238. 9 October 2019

researchers deserve equitable funding, particularly when it comes to studying disparate health in similar communities.

Prioritized Access to Vaccination for People with Disabilities and the

Elderly: As you know, people with disabilities are disproportionately affected by the COVID-19 virus, including people with intellectual and developmental disabilities (IDD) and disabilities with underlying health conditions. Additionally, The Center for Disease Control and Prevention (CDC) has stated that people with limited mobility are also at increased risk for contracting the virus because they cannot avoid coming into contact with others, such as direct caregivers and family members.⁴ Many states are addressing underlying health conditions in their vaccine rollout; however, we are hearing from our members that their patients with disabilities are having difficulty accessing the vaccine. We believe that this population should also have prioritized and streamlined access to the COVID-19 vaccines and encourage your administration to work with states to make this possible.

Additionally, during the ongoing vaccine rollout, we have seen the difficulty the elderly can face in accessing the vaccine. Many of the appointments are made online, which can be difficult for people over 65 to access on their own. We hope that as the vaccine continues rolling out and people over 65 continue getting vaccinated, even as other groups are eligible, that this process is made more user friendly for the elderly.

D. Maintaining Inpatient Rehabilitation Facility Waivers

Three-Hour Rule: AAPM&R is grateful for the waiver of the inpatient rehabilitation facility (IRF) three-hour rule in the CARES Act. When the PHE is lifted, the three-hour rule will go back into effect. We ask that the rule be reinstated after the pandemic, but with slight adjustments to expand the types of therapy that count towards the “three-hour rule”. The world after the PHE will not be the same world as before the COVID-19 outbreak. AAPM&R recognizes the overwhelming need for rehabilitation as COVID-positive patients recover from the immediate threat of the virus, but, particularly after weeks on a ventilator, may need rehabilitation to restore muscle function and avoid chronic muscle pain; optimize cardiopulmonary function; recover from multiorgan failure, anoxic brain injury, and strokes;

⁴ People with Disabilities. Centers for Disease Control and Prevention. Retrieved February 18, 2021, from: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-disabilities.html>

and help patients return to basic functions such as speaking and swallowing. AAPM&R asks you to work with the Centers for Medicare and Medicaid Services (CMS) to expand the types of skilled therapy rehabilitation physicians may prescribe that count towards the “three-hour rule” in addition to physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), and orthotics and prosthetic services (O/P). AAPM&R asks you to direct the agency to include other skilled services, as determined by the patient’s rehabilitation physician, such as recreational therapy,⁵ psychological and neuropsychological services, and respiratory therapy. These therapies may have increased demand for those recovering COVID patients. AAPM&R members know that all these therapies are part of the comprehensive treatment IRF patients receive. If these therapies count towards the “three-hour rule,” IRFs will be more apt to provide these services.

AAPM&R does not believe that expanding the “three-hour rule” will come with an associated cost. The current intensity of therapy requirement outlined in the “three-hour rule,” allowing the current four therapies (PT, OT, SLP, O/P) to count towards the 15 hours of therapy a week furnished to IRF patients, was instituted in 2010. Prior to 2010, before the intensity of therapy requirement was limited to the current four therapies, IRF admissions were at the same level as they were after the 2010 intensity of therapy requirement was limited and remained at nearly the same level through 2017.

AAPM&R has long advocated for rehabilitation physicians to be able to prescribe this expanded list of skilled therapies and apply them to the “three-hour rule.” We believe, now more than ever, that IRF patients, including those that are recovering from COVID-19, will require these other skilled therapy modalities to optimize their function and get the most out of inpatient rehabilitation. Rehabilitation physicians, through their years of higher education and experience, are equipped to determine what combination of therapies patients need.

60% Rule: CMS waived the 60% rule in IRFs early in the PHE. The 60% rule is a mechanism that attempts to ensure that only the most appropriate patients are admitted to an IRF level of rehabilitation care. The rule requires that 60% of an IRF’s patient population have a diagnosis that is

⁵ Recreational therapy is a vital therapy used to re-integrate people with disabling conditions and chronic illnesses back into society and function independently. Recreational therapy includes teaching patients to do things like ride the bus or get groceries.

included in a list of 13 diagnosis codes to be eligible to receive Medicare/Medicaid funding.

Many recovering COVID-19 patients will continue to need the comprehensive medical and functional care provided in IRFs and by rehabilitation physicians. Many COVID-19 patients, however, do not fall under the 60% rule, as this is a new disease with long-term issues and cardiac/pulmonary diagnoses do not currently count toward the 60% rule. As such, we request either the 60% rule be permanently waived or that the diagnosis codes be revised to include cardiac and pulmonary diagnoses and/or COVID-19 and resulting conditions.

IRFs who are currently treating patients with post-COVID syndrome will likely need to turn away similar patients after the PHE if the 60% rule is not waived or altered. This will also apply to recent survivors of critical COVID-19 cases who are being discharged from acute care will continue to require care after several weeks on a ventilator.

II. Physician Reimbursement and Budget Neutrality

It is vital to physiatry practices that a permanent solution be applied to budget neutrality in order to stop harmful cuts to physician reimbursement. The Medicare Physician Fee Schedule (PFS) Final Rule for FY 2021 includes a necessary and appropriate increase to payments for evaluation and management (E&M) codes used in providing primary care. Due to the fee schedule's budget neutrality requirement, these increases in E&M reimbursement were proposed to be offset by a reduction in the "conversion factor" (i.e., the dollar amount used to calculate reimbursement for specific procedures) of almost 11 percent (from \$36.09 to \$32.26), resulting in a major cut to overall physician reimbursement, which would have been effective January 1, 2021. However, the Consolidated Appropriations Act included a partial and temporary "fix" to these provider reimbursement cuts.

The bill injects approximately \$3 billion into the PFS for 2021, resulting in an approximate 3.75% increase to all services to mitigate the scheduled cuts. These additional payments apply only for 2021 and will not result in additional adjustments due to budget neutrality. The bill also delays the implementation of the new "complex patient add-on" code (G2211) for three years (until January 1, 2024). The removal of this code further reduced the impact of the downward budget neutrality adjustments outlined in the PFS final rule. These actions have delayed the larger payment cut, but further action will be needed this year and beyond. We encourage the Biden

administration to work with Congress to prevent future budget neutrality cuts while maintaining the appropriate increases to E&M payment.

III. Scope of Practice Concerns

AAPM&R has continued concerns about the October 3, 2019, Executive Order (EO) #13890 entitled, “Protecting and Improving Medicare for our Nation’s Seniors” and implores the Biden administration to avoid expanding scope of practice of non-physician practitioners into physician responsibilities. The EO #13890 mandated HHS to propose several reforms to the Medicare program, including ones that eliminate supervision and licensure requirements for professionals, such as Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), that are more stringent than other applicable federal or state laws and that limit such professionals from practicing at the top of their profession. Following the EO #13890, CMS proposed several concerning scope of practice policies and the Department of Veterans Affairs has also released concerning directives to permit non-physician providers (NPPs) to practice without the clinical supervision of physicians and without regard to state scope of practice law.

Furthermore, because of the PHE, many federal and state regulations regarding supervision of advanced practice providers (APPs) and their scope of practice were quickly altered to allow the flexibility of expanding the workforce to address the health care crises. AAPM&R supported temporary expansions to ensure patient access to some level of care during the height of the public health crises, but strongly opposes proposals to make the scope of practice expansions permanent. Many of the pre-COVID and current provisions include independent practice, dissolution of collaborative practice agreements, permission to perform diagnostic testing traditionally required by physicals, among other concerning requests. While we consider PAs and APRNs to be a vital part of the caregiving team; we strongly oppose the independent practice of APPs in the provision of rehabilitation care or the broader practice of medicine. We are concerned that further changes to eliminate Medicare supervision and licensure requirements would dynamically impact the widely adopted team-based approach to health care that ensures patients receive safe and high-quality health care. In addition, changes in VA policies to remove scope of practice safeguards will allow for APPs that have not been adequately trained to perform procedures that are outside the scope of their licensure, ultimately leading to a lower standard of care for veterans. Beyond the PHE, supporting physician-led health care teams is aligned with most state scope of practice laws.

A physician-led, team-based approach to patient care has proven to be the successful model to improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients. Relying on physician leadership is the most effective approach to maximizing the unique and complementary skill sets of all health care professionals on the team to help patients achieve their care goals. Many physicians spend over 11 years in medical training and more than 10,000 hours of clinical experience in order to ensure they are properly trained and educated to diagnose and treat patients. There is a significant disparity in the education and training that exist between physicians and APPs. For example, nurse practitioners (NPs), the largest category of APRNs, must only complete 2-3 years of graduate level education and 500-720 hours of clinical training. Though touted as a cure for the health care workforce shortage, the growth of NPs has been achieved with the spread of nurse practitioner programs, including online programs that promote completion in as little as 18-24 months and which typically require students to secure their own internship to complete their 500-720 hours of clinical training. Furthermore, physician assistant programs are two-years in length and require 2,000 hours of clinical care. Neither nurse practitioner nor PA programs include a residency requirement and have substantially lower examination requirements prior to licensure. We encourage CMS to take a close look at the stark differences in education and training as briefly described. These differences demonstrate that the level of acumen obtained by physicians throughout their extensive education and training is simply not comparable to the education and training of nurse practitioners or physician assistants and is a primary example of the continued need for the physician-led, team-based approach to patient care.

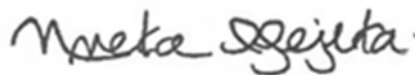
Supporters of scope of practice expansion commonly argue that provision will result in increased access to care. However, in reviewing the actual practice locations of APPs, it is clear that these providers tend to work in the same areas as physicians. For example, nurse practitioners tend to work in close proximity to physicians, including in large urban areas, regardless of the level of autonomy they are granted at the state level. This yields sincere doubts that scope of practice proposals suggesting to increase patient access would have a significant positive impact on access to care. We encourage the Administration to carefully review and consider fact-based resources, including a thorough review of the substantial differences in education and training of APPs relative to physicians, the impact on the overall cost and quality of care, and data regarding impact on patient access before contemplating any further scope of practice expansions.

IV. Dedicated Focus on Longitudinal Studies of Function and Quality of Life

The shift from volume-based to value-based health care reimbursement has been at the forefront of the U.S. healthcare system for years, but for typical health care delivery organizations where most physiatrists deliver care, the transition to value-based reimbursement is still in early stages and is inconsistent across payers. As a result, this transition has not reached the critical stage for most providers to change their practice patterns. Further, the current focus of the transition to a value-based system is focused on short term improvements and cost cutting with little evidence to show where value is provided. The desire to focus on value-based health care, including chronic disease prevention and management is apparent, yet it has not come to fruition due to the lack of focus on studying longitudinal outcomes of function and quality of life. AAPM&R strongly advocates for greater dedication to study longitudinal outcomes specific to restoring function and quality of life to advance our transition from a volume-based to a value-based health care environment, an area psychiatry is specifically trained to lead.

Thank you for your consideration of these comments. Please consider AAPM&R a resource in your efforts to streamline prior authorization. For more information, please contact Reva Singh, Director of Advocacy and Government Affairs at AAPM&R at rsingh@aapmr.org or 847.737.6030.

Sincerely,



Nneka Ifejika, M.D., M.P.H., F.A.H.A
Chair, Health Policy & Legislation Committee

CC:

Norris Cochran
Acting Secretary, Department of Health and Human Services

Xavier Becerra
Secretary-Designate, Department of Health and Human Services

Sean McCluskie
Chief of Staff, Department of Health and Human Services

Jeff Zients
White House COVID-19 Response Coordinator

Natalie Quillian
Deputy Coordinator, COVID-19 Response

Marcella Nunez-Smith
Chair, COVID-19 Health Equity Task Force

Christen Linke Young
Deputy Director for Health and Veterans Affairs, Domestic Policy Council

Jessica Schubel
Director of ACA and Health Care Policy, Domestic Policy Council

Kimberly Knackstedt
Director of Disability Policy, Domestic Policy Council

Elizabeth Richter
Acting Administrator, Centers for Medicare and Medicaid Services

Chiquita Brooks-LaSure
Administrator-Designate, Centers for Medicare and Medicaid Services

Arielle Woronoff
Director, Office of Legislation, Centers for Medicare and Medicaid Services

Lee Fleisher
Director, Center for Clinical Standards and Quality, Centers for Medicare
and Medicaid Services
Chief Medical Officer, Centers for Medicare and Medicaid Services

Ing-Jye Cheng
Director, Chronic Care Policy Group, Centers for Medicare and Medicaid
Services

Jeanette Kranacs
Deputy Director, Chronic Care Policy Group, Centers for Medicare and
Medicaid Services

Todd Smith
Director, Division of Institutional Post-Acute Care, Chronic Care Policy
Group, Centers for Medicare and Medicaid Services

Alison Barkoff
Acting Administrator, Administration for Community Living